TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH OF DALLAS

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-17-1177-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 22, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "they have not paid what we determine is the correct allowable per the APC allowable per the APC allowable per the TDI DWC fee schedule for the following account. Per the TDI / DWC fee schedule this account qualifies for an Outlier payment . . . "

Amount in Dispute: $1,764.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary:

1. Codes 74177 and 71260 have a Q3 status, which means they are subject to a composite APC payment.
2. Codes 70450 and 72125 have a Q3 status, which means they are subject also to a composite APC payment.
3. Codes 36415, 80053, and 85025 have a Q4 status and are packaged under OPPS when another code billed on the same claim has a J2 status. Code 99285 has the J2 status.
4. Codes 96374 is packaged to code 74177 and code 96375 is packaged to code 71260.

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 7, 2016	Outpatient Hospital Services	$1,764.48	$1,764.48

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 236 – THIS BILLING CODE IS NOT COMPATIBLE WITH ANOTHER BILLING CODE PROVIDED ON THE SAME DAY ACCORDING TO NCCI OR WORKERS COMPENSATION STATE REGULATIONS /FEE SCHEDULE REQUIREMENTS.
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
   - 435 – PER NCCI EDITS, THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF THE COMPREHENSIVE PROCEDURE.
   - 616 – THIS CODE HAS A STATUS Q APC INDICATOR AND IS PACKAGED INTO OTHER CODES THAT HAVE BEEN IDENTIFIED BY CMS.
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
   - 630 – THIS SERVICE IS PACKAGED WITH OTHER SERVICES PERFORMED ON THE SAME DATE AND REIMBURSEMENT IS BASED ON A SINGLE COMPOSITE APC RATE.
   - 767 – REIMBURSED PER O/P FG AT 200%: IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (WITH CERT) NOT REQUESTED PER RULE 134.403(G)
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule.

   The insurance carrier denied or reduced the disputed services with the claim adjustment reason codes listed above. The only issues in dispute are regarding the appropriate amount of the fee(s).

   The respondent contends that "Texas Mutual paid $2,597.40. No additional payment is due."

   The respondent further contends in points 1 through 4, as enumerated in their position statement, that per Medicare payment policies and division rules, several of the procedure codes billed on the claim are subject to composite payment and packaging rules reductions. Review of the submitted information finds the respondent's assertions regarding composite payment and packaging are supported—the specifics of which will be explained in detail in the payment calculation section of Finding 2, below.

   The requestor, on the other hand, argues that "Per the TDI / DWC fee schedule this account qualifies for an Outlier payment . . . " in support of which, the requestor submitted a screen print of the calculation produced by a CMS-published software program—Medicare's Inpatient Pricer—intended for use in calculating the reimbursement amounts for hospital facility services provided in treatment of patients admitted on an inpatient basis.

   However, review of the submitted medical bill and documentation finds that the disputed services were rendered as outpatient services and not subject to reimbursement under the division's *Hospital Facility Fee*

Guideline—Inpatient, but are rather (as stated above) subject to the division's *Hospital Facility Fee Guideline—Outpatient*, pursuant to Rule §134.403. As such, the requestor's submitted evidence regarding the inpatient fee calculation is not relevant to the outpatient services in dispute.

Nevertheless, review of the submitted documentation finds that the requestor's contention that the disputed services qualify for an outlier payment is indeed justified. The details of the outlier payment calculation are also explained below in the payment calculation section of Finding 2.

2. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

   Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure codes billed and supporting documentation. A payment rate is established for each APC. Hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items (including services billed without procedure codes) is packaged into the payment for each APC. A full list of APCs is published quarterly in the OPPS final rules, which are publicly available from the Centers for Medicare and Medicaid Services (CMS). Reimbursement for the disputed services is calculated as follows:

   - Procedure codes 36415, 80053, and 85025 have status indicator Q4, denoting packaged laboratory services. Payment for this service is included in the payment for procedure code 99285 billed on the same claim. Payment for packaged services is included in the reimbursement for primary service(s). Separate payment is not recommended; however, the packaged revenue may be considered in allocating outlier payments.
   - Procedure codes 72125, 74177, 70450, and 71260 have status indicator Q3, denoting packaged codes paid through a composite APC. Services assigned to composite APCs are major components of a single episode of care; the hospital receives one payment under a composite APC for multiple separate major services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. These services are assigned composite APC 8006, for computed tomography (CT) services including contrast. If a "without contrast" CT procedure is performed on the same date as a "with contrast" CT, APC 8006 is assigned rather than APC 8005. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged revenue costs are allocated to the composite line-item in proportion to other separately paid services on the claim.

     Per OPPS Addendum A, APC 8006 has a payment rate of $493.91, multiplied by 60% yields an unadjusted labor-related amount of $296.35. This amount multiplied by the facility's annual wage index of 0.9731 yields an adjusted labor-related amount of $288.38. The non-labor related portion is 40% of the APC rate—or $197.56. The sum of the labor and non-labor related amounts is $485.94.

     Per 42 *Code of Federal Regulations* §419.43(d) and *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $3,250, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.234. This ratio multiplied by the billed charge of $13,681.75 yields a cost of $3,201.53. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this line of $485.94 divided by the sum of all APC payments is 50.40%. The sum of all packaged costs is $520.12. That amount multiplied by 50.40% is the portion of packaged costs allocated to this composite line item, or $262.15. This amount added to the service cost yields a total cost of $3,463.68. The adjusted cost of this line item—including the proportionally allocated packaged costs—is greater than the annual fixed-dollar threshold of $3,250. The amount by which the cost exceeds 1.75 times the OPPS payment is $2,613.28. 50% of this amount is $1,306.64. The total Medicare facility specific reimbursement amount for this composite line, including the outlier payment, is $1,792.58. This amount multiplied by 200% yields a MAR of $3,585.16.

- Per Medicare's payment policy regarding NCCI edits, procedure code 96374 may not be reported with procedure codes 74177 and/or 71260 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Per Medicare's payment policy regarding NCCI edits, procedure code 96375 may not be reported with procedure code 71260 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code 99285 has status indicator J2 denoting hospital, clinic or emergency room visits (including observation and critical care services). These services are classified under APC 5025, which, per OPPS Addendum A, has a payment rate of $486.04. This amount multiplied by 60% yields an unadjusted labor-related amount of $291.62. This amount multiplied by the facility's annual wage index of 0.9731 yields an adjusted labor-related amount of $283.78. The non-labor related portion is 40% of the APC rate or $194.42. The sum of the labor and non-labor related amounts is $478.20. The adjusted cost of these services, including the allocated proportional packaged costs, does not exceed the annual fixed-dollar threshold of $3,250. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $478.20. This amount multiplied by 200% yields a MAR of $956.40.
- Procedure codes J2270, J2405, and Q9967 have status indicator N denoting packaged codes with no separate payment; reimbursement is packaged with payment for other services (including outliers).
- Procedure code 93005 has status indicator Q1 denoting STVX-packaged codes; payment for this service is packaged into the payment for any other procedures with status indicators S, T, V, or X that are billed for the same date of service. This code may be separately payable only if no other such procedures are billed for the same date. Review of the submitted information finds that OPPS criteria for separate payment have not been met. Payment for this service is included in the payment for procedure codes 72125, 74177, 70450, 71260, 96374, 96375, and 99285 billed on the same claim. Separate payment for this service is not recommended.

3. The maximum allowable reimbursement for the services in dispute is $4,541.56. The amount previously paid by the insurance carrier is $2,597.40. The requestor is seeking additional reimbursement in the amount of $1,764.48. This amount is recommended

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,764.48

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,764.48, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	January 27, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.